

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS255AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/04/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>LACY LANE RETIREMENT HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>313 LACY LANE</b> <b>LAS VEGAS, NV 89107</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p><b>Initial Comments</b></p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 2/4/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was 6 residents. Three (3) resident files were reviewed and 5 employee files were reviewed. One discharged resident file was reviewed.</p> <p>Complaint #NV00023982 was substantiated. See TAGS Y944 &amp; Y963.</p> <p>The following deficiencies were identified:</p>	Y 000		
Y 944 SS=D	<p><b>449.2749(2) Resident File - Discharge Documentation</b></p> <p>NAC 449.2749</p> <p>2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person</p>	Y 944		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 944	Continued From page 1  responsible for the resident was contacted to inform him of the death.          This Regulation is not met as evidenced by: Based on record review and interview on 2/4/10, the facility did not provide proper documentation regarding a resident who had expired.  Severity: 1 Scope: 1  Complaint #NVS00023982	Y 944			
Y 963 SS=F	449.2754(4)(a)(b) Alzheimer's  NAC 449.2754 4. A residential facility which provides care to persons with Alzheimer's disease must be administered by a person who: (a) Has not less than 3 years of experience in caring for residents with Alzheimer's disease or related dementia in a licensed facility; or (b) Has a combination of education and training that the bureau determines is equivalent to the experience required pursuant to paragraph (a).       This Regulation is not met as evidenced by: Based on record review on 2/4/10, the facility failed to ensure 3 of 5 employees had the required alzheimer's training (Employees #3, #4 & #5).	Y 963			

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Y 963	Continued From page 2  Severity: 2    Scope: 3  Complaint # NVS00023982	Y 963			

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